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November 23, 2005

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RE: John A. Horton
DOB: 10/26/68

Dear Mr. Koufman:

I have reviewed materials forwarded to me by your office with respect to John A. Horton, a thirty three year-old inmate of the Dartmouth House of Correction who expired on September 29, 2002. I have been requested to review the quality of medical care which he received during the period of his incarceration which extended for an interval of more than two years.

Mr. Horton had a lengthy history including HIV infection, hepatitis C infection, depression, chronic migraine headaches, dizziness and Crohn's disease. The materials available to me included records of the House of Correction Dartmouth, Massachusetts General Hospital, Lemuel Shattuck Hospital , and Cape Cod Hospital. The medical history of this patient includes some fifty-nine references to interactions with healthcare workers during the interval of his imprisonment. Multiple health problems were encountered during this period and appropriate management was provided. A history of migraine headaches was prominent among the complaints and treated with Inderal, a beta-blocker agent, with evidence of some success in diminishing the symptom contained within the prison record. Moreover, a CT head scan obtained at the Lemuel Shattuck Hospital on August 27, 2001 revealed no neurological pathology. I cite this particular entity because headaches assumed a more significant element in the patient's course immediately prior to his demise.

During this period of imprisonment, Mr. Horton was admitted to Massachusetts General Hospital in August 2000 with back pain culminating in the discovery of an epidural abscess requiring urgent laminectomy and incision and drainage of the purulent collection. Recognition of his HIV infection and need for treatment resulted in the institution of the HAART program. Subsequently however, the patient, in June 2001, refused further management of his HIV in spite of the beneficial results obtained during this long course of therapy. The data reveal a lowering of his CD4 counts from January 2001 at 794 to 460 on September 14, 2002. The latter level is slightly below the lower limit of normal.

If we look more closely at the interval preceding the patient's death, it is reasonable to examine the course of illness manifested in the spring of 2002 and its subsequent development. Beginning with May 21, 2002 there is evidence of recurrent vomiting and abdominal pain. An abdominal CT examination on June 6, 2002 reported a negative abdomen and pelvis. A colonoscopy, which had been suggested to the patient in June 2002, was refused. In August 2002, there is evidence that headaches were increasing and the patient requested a new medication for this purpose on August 20. The record shows that in fact Cardizem 30 mg tid was added to his regimen. In September Dr. Andrews, the patient's physician, noted an abnormal funduscopic examination and requested that the patient undergo a head MRI in view of his HIV positivity,

abnormal eye examination and lengthy history of headache. Following a subsequent examination by another physician no significant abnormality was detected in terms of the patient's eyes. Dr. Andrews changed her order to a head CT scan cancelling the MRI but this examination was not concluded at the time of the patient's demise.

On September 28 the patient experienced mood swings, headache and tremors. On the following day he was found unresponsive on the floor with labored respirations and frothing at the mouth. Oxygen therapy and CPR were employed. The patient was intubated and subsequently transferred to St. Luke's Hospital and there resuscitative attempts were ineffective.

At post-mortem examination, conducted by Dr. George Kury, the cause of death was stated to be a sub-acute encephalitis. There was evidence of cerebral edema with cerebellar herniation and enlarged ventricles as well as a focal temporal lobe density. Also noted were hepatosplenomegaly and enlarged periportal lymph nodes with lymphadenopathy also noted in the cervical and peri-hilar areas.

In reviewing this matter, I believe that the prison medical care was consistent with the appropriate standards of diagnosis and treatment for this patient. In regard to the continued headache disorder demonstrated by Mr. Horton, management with a beta-blocker was certainly appropriate and when the condition exacerbated additional medication was prescribed consistent with an underlying diagnosis of migraine headache of long-standing nature. A prior head CT examination effectively ruled out a brain tumor as well as a chronic inflammatory process or a degenerative neurological syndrome.

Only in the month prior to his death was there a possible reason to believe that an additional medical issue was present. In addition to changing the patient's medication and ordering an imaging study, the patient's physician sought out consultation with respect to possible funduscopic abnormality.

However well-intentioned these efforts were, no therapeutic attempt to correct the overwhelming encephalitis would have been successful. It is clear that the presumed organism present would have been extremely virulent, and that its ability to inflict harm was aided by the patient's reduced resistance as a consequence of untreated HIV infection. In addition to these obvious biologic factors, the question may be raised as to the patient's acceptance of a protracted course of treatment of infection since he had declined treatment and testing on prior occasions.

I hold all opinions stated to a reasonable degree of medical certainty.

Please let me know if you have any questions concerning this matter.

Sincerely,

Robert H. Resnick MD

Robert H. Resnick, M.D.

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